



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

AHMED KHALIFA MD

MFDR Tracking Number

M4-18-0357-01

MFDR Date Received

October 12, 2017

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative

Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...as you can see from the attached report an examination was performed and documented as a Detailed Examination component and billed as 99204. See report for all 12 elements required for a general multi-system examination."

Amount in Dispute: \$172.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor conducted an E&M visit and billed Texas Mutual code 99214. TM declined to issue payment per the following. The documented History and Exam are both problem focused. The 2016 AMA CPT manual requires 2 of 3 of these components: Detailed History, Detailed Exam, and Moderate Complexity Decision Making. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
November 21, 2016	99214	\$172.67	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-150 – Payer deems the information submitted does not support this level of service.
 - 891 – No additional payment after reconsideration
 - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 225 – Submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 890 – Denied per AMA CPT Code description for level of service and/or nature of presenting problem.

Issues

1. What is the definition of CPT Code 99214?
2. Did the requestor submit sufficient documentation to support the level of service billed?
3. Is the requestor entitled to reimbursement for the disputed service?

Findings

1. The requestor seeks reimbursement for CPT Code 99214 rendered on November 21, 2016. The AMA CPT Code book defines CPT Code 99214 as follows "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family."

The Division will now address the insurance carrier's denial reasons for non-payment of CPT Code 99214.

2. The insurance carrier denied the disputed service with denial reduction code(s) CAC-150, CAC-16, 891, 225 and 890 (descriptions provided above.) The insurance carrier states in their position summary, "The documented History and Exam are both problem focused. The 2016 AMA CPT manual requires 2 of 3 of these components: Detailed History, Detailed Exam, and Moderate Complexity Decision Making. No payment is due."

Review of the requestor's position summary addresses the billing of CPT Code 99204, which is not identified as a disputed service on the "Table of Disputed Services." Although the requestor submitted a detailed position summary, the position summary addressed reasons for reimbursement that were not raised by the insurance carrier during the medical bill review process and were not indicated on the EOBs presented to MDR. The Division notes that although the carrier presented a denial indicating that the documentation does not support the services being billed, the requestor in this case did not refute or discuss the documentation denial in its position statement.

A review of the medical report dated November 21, 2016 does not support the documentation requirements which require "at least 2 of the 3 key components." The Division therefore, finds that reimbursement cannot be recommended for the disputed CPT Code 99214 rendered on November 21, 2016.

3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for CPT Code 99214 rendered on November 21, 2016.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 3, 2017
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 Texas Register 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiera hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.